HHSA BEHAVIORAL HEALTH SERVICES
TEN YEAR ROADMAP

OUR VISION, MISSION AND VALUES	OUR GUIDING PRINCIPLES	OUR COMMITMENT
Vision: Live Well San Diego – A region that is Building Better Health, Living Safely and Thriving **Mission**: To efficiently provide public services that build strong and sustainable communities **Values**: Integrity – Stewardship – Commitment	Promote Recovery, Resiliency, Discovery and Well-Being; Collaborate with Partners, Stakeholders and the Community; Maximize Funding; Driven by Data; Proactive Management; Ensure Regulatory Compliance; Utilize Evidence Based/Informed Practices	Work in partnership with our communities to provide quality behavioral health services empowering individuals with behavioral health needs to live healthy, safe and thriving lives.

OUR PRIORITIES				
PRIORITY	**SHORT TERM** Fiscal Years 16/17-18/19	**MID TERM*** Fiscal Years 19/20-21/22	**LONG TERM*** Fiscal Years 22/23-25/26	**TEN YEAR GOAL**
Homelessness and Housing	• Implement Project One for All (POFA), including the addition of 1,250 Assertive Community Treatment/Full Service Partnership treatment slots and 600 outreach/engagement slots (at a minimum). • Collect baseline data to evaluate effectiveness of POFA and plan for long term strategy to improve and/or maintain services. • Secure housing subsidies for POFA from committed housing entities. • Replicate East County Court homeless outreach services to ensure connection to appropriate health and human services and housing resources. • Work with the Court and Criminal Justice partners to conduct a study to determine the number of inmates who have serious mental illness and are at great risk of being homeless upon community release.	• Develop housing strategies based on evaluation of POFA outcomes and community needs. • Evaluate and adjust POFA strategy based on baseline data and initial outcomes, including potential expansion for individuals with serious behavioral health conditions leaving the jail.	• Implement housing strategies based on evaluation and adjustments from POFA outcomes and community needs. • Re-evaluate and adjust POFA strategy based on outcomes, including potential expansion for individuals with serious behavioral health conditions leaving the jail.	Address homelessness by increasing treatment, supportive services and permanent supportive housing for underserved individuals with serious mental illness.
Collaboration with Public Safety and Justice Partners	• Evaluate collaborative courts and develop strategies to address behavioral health gaps and improve public safety. • Develop behavioral health services designed for justice-involved youth and adults, in cooperation with criminal justice partners. Consider all levels of mental health needs, co-occurring treatment needs and criminogenic factors/approaches to improve public safety. • Support and evaluate the addition of licensed mental health case management clinicians in Public Defender's office. • Increase in-jail services to support discharge planning. • Develop and implement a co-occurring treatment program to support an in-county residential program for youth involved in the juvenile justice system. • Work with criminal justice partners to develop and implement coordinated processes for screening and assessment to identify high risk and/or high need offenders. • Support addition of clinical staff to serve youth in juvenile justice institutions.	• Monitor and evaluate coordinated processes for screening and assessment to identify high risk and/or high need offenders. • Evaluate the comprehensive system of services for the justice population. Adapt strategies and develop additional strategies as indicated considering all levels of behavioral health needs (including co-occurring needs) and criminogenic factors/approaches to improve public safety. • Evaluate the need for a PERT clinician in Probation's Mentally Ill Offender unit. • Work with criminal justice partners to plan	• Implement new strategies identified to support a comprehensive system of services for the justice population which considers all levels of behavioral health needs (including co-occurring needs) and criminogenic factors to improve public safety. • Work with criminal justice partners to implement improved transportation to enhance service engagement by offenders.	Deliver coordinated and comprehensive behavioral health services to the justice population in collaboration with criminal justice partners.

Strategies will be continuously refined via annual BHS Community Engagement and other Stakeholder forums and are dependent on funding availability and new and/or changing laws and regulations.

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	• Engage Health Plans in dialogue around capacity to screen and refer offenders with mild to moderate mental illness to appropriate services. • Provide competency restoration services for youth in the community. • Support a new specialized Trauma Responsive Unit in a Juvenile Institution. • Develop Pathways to Well Being training for probation workforce. • Increase quality of care and program adherence to evidence based practice for specialized needs of juvenile and adult justice population through the use of the Correctional Program Checklist (CPC).	for improved transportation to enhance service engagement by offenders. • Ensure Continuum of Care Reform (CCR) and Pathways to Well Being Systems incorporate probation populations. • Engage Health Plans in coordination of care for individuals with mild to moderate mental illness.		
Behavioral Health Continuum of Care	• Partner with key community stakeholders to generate solutions and develop recommendations for improvements to the integrated behavioral health continuum of care with a focus on acute care and jail services. • Evaluate the comprehensive BHS System of Care to identify service and capacity gaps and develop plans to address. • Enhance outpatient mental health clinics to increase mental health and recovery services.	• Implement recommendations for system improvement based on identified gaps in service and capacity.	• Continuously evaluate and adjust planning to reflect identified needs and gaps in service for the behavioral health continuum of care.	Continuously identify and address needs and gaps for the Behavioral Health Services (BHS) Systems of Care.
Underserved and Unserved Populations	• Develop and implement Commercially Sexually Exploited Children (CSEC) Program. • Develop and implement LGBTQI Program for children/youth and Transitional Aged Youth (TAY). • Evaluate and support interpreter requirements across programs. • Evaluate opportunities for increased cultural competency training and programming for the Deaf/Hard of Hearing community. • Expand outreach to veterans, LGBTQI and older adults through the *It's Up to Us* countywide media campaign. • Implement TAY Workgroup Plan and recommendations.	• Increase TAY services to address mental health, substance use conditions and homelessness. • Evaluate and adjust CSEC service needs. • Evaluate and adjust LGBTQI service needs. • Evaluate gaps in services, identify new needs and adjust services for underserved and unserved populations.	• Re-evaluate gaps in services, identify new needs and adjust services for underserved and unserved populations.	Expand behavioral health services for adults, children and youth transitioning to adulthood, specifically for underserved and unserved populations, including but not limited to, racial, ethnic, refugee and lesbian, gay, bisexual, transgender and questioning (LGBTQI) populations.
Suicide Prevention	• Implement Behavioral Health Advisory Board (BHAB) Suicide Prevention Workgroup (SPW) Recommendations identified in the SPW Feasibility Report including the use of the Columbia Suicide Severity Rating Scale (C-SSRS) throughout the County as appropriate per setting and available resources. • Expand school based suicide prevention services countywide, with added bullying prevention component. • Support suicide prevention efforts for probation involved youth through trainings and the establishment of referral pathways.	• Evaluate implementation of BHAB SPW recommendations. • Explore enhancement of bullying prevention services. • Evaluate and update the San Diego County Suicide Prevention Action Plan.	• Implement new suicide prevention strategies based on the County of San Diego's Suicide Prevention Action Plan.	Enhance suicide prevention efforts including support and resources for the most vulnerable populations.

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	• Update the San Diego Suicide County Prevention Action Plan for the next five year period.			
Crisis Services	• Implement two (2) crisis stabilization units (CSU) in North County; evaluate and develop plan for expansion if indicated. • Open Crisis Residential Facility in North Inland Region. • Centralize and increase number of emergency screening unit (ESU) beds available for children/youth. • Implement new and expand existing walk-in/urgent clinic capacity. • Evaluate need for more crisis response teams and plan for implementation if indicated. • Plan for the ongoing availability of children/youth psychiatric inpatient beds.	• Implement plan for additional crisis services countywide as indicated. • Evaluate existing crisis response education and training and adjust as indicated. • Explore establishing a crisis residential for youth pending legislation passage to allow for licensing and reimbursement. • Evaluate need for additional Walk-in/Urgent services and develop plan for expansion if indicated.	• Work with critical partners to evaluate existing crisis services and adjust planning as indicated.	Enhance crisis services and ensure continued education and training to law enforcement, emergency personnel and first responders.
Aging Population	• Increase support of caregivers by expanding services countywide. • Evaluate System of Care needs for older adults with serious mental illness (SMI) consistent with State Older Adult Framework and community needs.	• Explore expanded services for the aging population with SMI. • Evaluate expansion of caregiver services and adjust as indicated.	• Implement expanded services for the aging population with SMI as indicated.	Implement innovative approaches to screen and treat the aging population with serious mental illness and increase services to caregivers of those with cognitive declines that impact daily functioning and living.
Collaboration with Schools	• Expand prevention and early intervention school age programs to all regions with a focus in Southeast San Diego and specialized component in east region for refugee population. • Increase education sector awareness of BHS programing through the HHSA School Collaborative and utilize partnership to identify system improvement opportunities.	• Evaluate services and training to ensure effective cross-system collaboration. • Plan and begin implementation of system improvements based on partnerships developed through the HHSA School Collaborative.	• Continuously re-evaluate and plan for system improvements based on partnerships developed through the HHSA School Collaborative.	Promote collaborative partnerships with schools to address behavioral health issues.
Care Coordination	• Increase intensive institutional case management to facilitate step-down from inpatient to outpatient services. • Increase case management availability countywide to better connect clients to services. • Develop and implement a 'Warm Handoff' infrastructure. • Implement a communication platform for seamless access to incoming and outgoing shared messaging and clinical information.	• Evaluate case management availability countywide and develop plan for expansion to better connect clients to services. • Implement interoperable solutions through secure health information exchange technology to support increased care coordination and promote better outcomes.	• Achieve Person-Centered Service Delivery goals with full ConnectWellSD implementation by linking data, departments and programs and creating more virtual working relationships, making it easier and faster to provide service as a team, for a better customer experience.	Improve care coordination for discharging or transitioning clients to behavioral health and physical health resources.

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Workforce	• Evaluate workforce qualifications and salaries across BHS programs. • Develop plan to address staffing levels and compensation to ensure appropriate level of care across programs; begin implementation. • Support behavioral health workforce training, mentoring and education. • Redesign and extend community psychiatry fellowship.	• Continue implementation addressing staffing levels/compensation to ensure appropriate level of care across programs. • Develop plan for ongoing support of workforce education and training; implement as indicated.	• Implement and continuously evaluate plan for ongoing support of workforce education and training.	Enhance workforce to retain qualified behavioral health staff with competitive salaries and qualifications and ensure appropriate staff for oversight of programs.
Substance Use Disorder Organized Delivery System	• Develop recommendation to opt-in to 1115 Waiver to develop a Substance Use Disorder (SUD) Organized Delivery System, develop and submit rates and implementation plan. • Begin initial implementation of SUD Organized Delivery System including, detox, recovery, narcotic treatment and residential treatment services. • Incorporate SUD prevention strategy into SUD Organized Delivery System, including targeted education to vulnerable populations.	• Continue implementation of SUD Organized Delivery System according to implementation plan. • Increase educational efforts and media campaigns focusing on SUD prevention, such as the suicide prevention and stigma reduction campaign *It's Up to Us*.	• Fully implement the SUD Organized Delivery System.	Implement an innovative Substance Use Disorder Organized Delivery System.
Children's Behavioral Health Services	• Begin converting children's mental health programs to Full Service Partnerships. • Evaluate the full complement of children's behavioral health services through the comprehensive BHS System of Care evaluation and develop plan to address gaps in children's services. • Collaborate with Child Welfare Services (CWS) and Probation on Continuum of Care Reform (CCR) planning. • Expand Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) from the Katie A. Subclass population to all eligible EPSDT MediCal beneficiaries.	• Continue the conversion of children's mental health programs to Full Service Partnerships. • Begin implementation of system improvements to support children's behavioral health services. • Support development and execution of Continuum of Care Reform (CCR) implementation plan.	• Evaluate Continuum of Care Reform (CCR) implementation and adjust as needed. • Evaluate implementation of changes and enhancements to children's behavioral health services and adjust as indicated.	Attend to the behavioral health needs of children and youth in the context of changing regulations.
Long Term Care	• Develop a Long Term Care (LTC) strategy (including exploration of implementing SNF special treatment) to reduce the need and reliance on long term care resources by better understanding systems issues and enhancing the care continuum. • Reorganize BHS Clinical Director's Office to support LTC Strategy. • Ensure appropriate level of support for San Diego County Psychiatric Hospital.	• Begin implementation of LTC strategy to include enhancement of primary care interventions and alternatives to LTC.	• Continue implementation and continuous improvement of LTC continuum.	Ensure a continuum of Long Term Care is available to meet individual needs.

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